The menopause: stressors and facilitators

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Between about ages 40 and 55 years, women experience a transition known as the menopause, which marks the end of their childbearing years. Although the most striking feature of the menopause is the cessation of menstruation, other biologic and psychosocial events occur and can be classified as stressors and "facilitators". For a predisposed group of women the stressors are likely to cause psychiatric disorders. At the same time, the facilitators are opportunities for personal growth and development. Physicians who understand both types of events during this phase of life and who are sensitive to the overall effects of ageing on marital partners can provide comprehensive care to the menopausal patient rather than automatically pursuing drug therapy (substitution hormonal therapy) alone.

Entre l'âge de 40 et 55 ans environ, les femmes vivent une période de transition appelée ménopause marquant la fin des années de fertilité. L'événement le plus apparent de la ménopause est la fin des menstruations, mais d'autres événements biologiques et psychosociaux se produisent et jouent un rôle d'agents catalyseurs ou de facteurs de stress. Pour certaines femmes susceptibles, les facteurs de stress peuvent provoquer des problèmes psychiatriques. Les catalyseurs, par contre, peuvent contribuer à la croissance et au développement personnel. Les médecins qui comprennent les deux genres d'événements que peut comporter cette période de la vie et qui sont conscients des effets généraux du vieillissement sur le couple peuvent soigner de façon compréhensive la femme ménopausée, plutôt que de se contenter de donner un traitement aux médicaments (hormonothérapie substitutive).

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The relationship between hormone levels and psychosocial changes during the menopause is not clear: the latter have been studied only in the past 20 years. Stressors contribute to biologic and psychosocial dysfunction during this phase but may be offset by "facilitators", events that offer opportunities not only for women undergoing the menopause but also for the physicians who are called upon to provide care.

Evaluation of the biologic and psychosocial changes during the menopause has been hampered by the lack of standard definitions. One international attempt to define terms differentiates between the climacterium and menopausal phases.[1] The climacterium is seen as the period from about ages 40 to 55 years when a woman passes from the reproductive to the nonreproductive stage. This period is subdivided into the premenopause, in which the menstrual cycle is likely to be irregular, the menopause, which is the time of the final menstruation, and the postmenopause, which is marked by involution of the ovaries. Most studies to date have not differentiated between these terms. Our review, therefore, uses the widespread term "menopause" as synonymous with "climacterium".

The menopause and psychiatric symptoms

Past reviews and comparisons have been unable to find a specific constellation of psychiatric symptoms that characterizes the menopause,[2-4] perhaps because the symptoms have not been systematically studied. Reports have been limited to the patients' descriptions and have not included objective checks or controls for bias in symptom reporting.

Although depressive disorders, particularly mild ones, are treated twice as often in women as in men, they do not correlate with the menopause.[5,6] According to an urban survey, however, major depression tends to occur most often at ages 46 to 65 years, when the discrepancy between the sex-specific incidence rates is low.[7] In patients predisposed to depressive episodes Winokur[8] showed that the incidence of depressive illness was not greater during the menopause than at other times, nor was the menopause associated with an increase in the incidence of depressive psychosis or suicide.[9] So far there is no evidence that the menopause is directly associated with a specific psychiatric diagnostic entity.

Stressors related to the menopause

Biologic

Various endocrine dysfunctions have been observed in patients with affective disorders, including women in the menopausal age group.[10,11] Some of the abnormalities, such as

decreased levels of growth and luteinizing hormones and varied prolactin levels, may be due to primary hypothalamic or pituitary dysfunction rather than to fluctuations in the endocrine function of peripheral organs.[12-15] In a well controlled study depressed men and depressed menopausal women showed a normal response of the hypothalamic–pituitary–gonadal axis to the infusion of gonadotropin releasing hormone.[16] The same infusion in postmenopausal women aged 46 to 64 who had primary endogenous unipolar depression with no physical or laboratory abnormality produced levels of luteinizing hormone about 33% below those of healthy postmenopausal controls with no history of personal or family psychiatric illness. The researchers hypothesized that, rather than having a pituitary abnormality, the patients had no internal feedback to the hypothalamus to increase the output of gonadotropin releasing hormone.

However, the major hormonal change — the decrease in estrogen levels — has not been clearly linked with emotional problems. Likewise, catecholamines and estrogen interact, but the exact mechanism and its effects on psychologic symptoms are also uncertain.[17-19]

Clearly, biologic changes do affect women's sexual desire. In a study of 50 couples, among whom all the women were postmenopausal, the most common problems were loss of orgasm, dyspareunia and secondary erectile difficulty. Of the 50 women, 14 had experienced changes in sensitivity to touch that ranged from hyperirritability to numbness. Interestingly, estrogen has been shown to affect neural transmission time.[20] Estrogen therapy will offset these biologic effects but does not address the interpersonal problems and sociocultural values that may be the psychosocial stressors.

Psychosocial

Neugarten and colleagues[21] found that increased age and experience with menopause significantly improved women's ability to cope with the transition: younger women held more negative and undifferentiated attitudes than did their older counterparts.

In the 1940s Deutsch[22] wrote of the menopause as "a narcissistic mortification" by which a woman "loses all she received during puberty". More recent literature, such as Parlee's work,[23] acknowledges that women cannot be seen solely in terms of their reproductive cycle. The biologic changes are often only as important as they are perceived to be within the particular sociocultural environment. A transcultural survey found that women who want to produce more children have a negative attitude toward the menopause.[2] Among the Fulani in Sudan the menopause is virtually social death, as a woman gives away the last of her calabashes and cattle to her children and goes to live with her eldest son.[24]

The menopause is part of the much larger process of ageing, and attitudes toward the two overlap. The decline in physical and intellectual abilities associated with ageing is especially difficult for people to accept in societies that value youthful appearance and attractiveness more than experience.[25] The menopause is often regarded as a milestone on the road to death, a reminder of human vulnerability.[26]

Ageing, like the phenomena of the menopause, is accompanied by role changes that are related not only to oneself but also to one's spouse, parents and children. Women must adjust to giving up the maternal role, and the loss is particularly complicated and stressful if the children have become maladjusted adults. Those women who have totally devoted themselves to the raising of children are likely to harbour feelings of guilt and failure if the children do not turn out as expected.[25]

When children are grown and married or otherwise out of the home, both parents may experience feelings of disinvestment in the "empty nest", and these feelings may lead the partners to withdraw or withhold support for each other's developmental challenges.

Changes in sexual performance can be the source of psychologic stress for both partners. Interpersonal issues and sociocultural values can create barriers that underline the biologic effects. Men may experience physical difficulties with penetration, slowness of sexual response and various inhibiting emotions, such as fear of hurting, feelings of rejection or inadequacy, and anger.[20]

Societal expectations for women reaching their middle years during the 1980s contrast sharply with those in the recent past and may lead to stress. The earlier caricature of a married, obese, idle, depressed woman — the traditional myth[27] — is impossible to reconcile with the current picture of a middle-aged woman exploring new careers, heading back to school for a master's degree or striking out on a path for independence, competence and personal growth. A woman may end up feeling she must choose between doing "nothing" at home or doing "everything".

The psychosocial stressors are numerous, and, despite the evidence against psychiatric illness specific to the menopause, many women seek help for complaints of a psychiatric nature in conjunction with the menopause. Thus, physicians need a thorough understanding of the "facilitators" that can offset some of the stressors.

"Facilitators" in the menopause

The restrictive concepts of loss and stagnation associated with the menopause are being increasingly challenged, and many studies are now focusing on the opportunities emerging during this phase of life. Developmental life phases for women no longer correlate with age, as they did in the past: social and biologic cycles for women do not necessarily coincide.[28]

According to Erikson's model of personality development,[29] generativity, defined as a new commitment to guiding younger generations, is the midlife task. According to this model, in midlife individuals shift from pouring all their energies into their advancement and begin caring for others in the broadest sense. This may apply more to men than women in the sense that many women have already invested in this type of generativity in raising their children. During the menopause creativity in one's own activities may be an added dimension for the already generative spouse and mother. Women may start a career as their

children become independent, thus entering the phase of career consolidation a decade or so after men.

The menopause can mean increased freedom, a fact that is clear in several sociocultural environments. For the Rajput woman in India the end of the reproductive cycle means that she becomes freer within her own household, can visit other households and for the first time is allowed to talk and joke with men.[24] Also, women of oriental background have been shown to welcome the end of childbearing.[2]

The "empty-nest syndrome" as a menopausal stressor has been increasingly challenged. Women who maintain a good relationship with their children and those whose identity is less child-centred do not feel threatened by the launching of their children into the adult world. Marital satisfaction may actually increase as stressful postadolescent children leave home.

With fewer time-consuming family responsibilities, women can set other priorities. Interestingly, this life phase parallels adolescence in its potential, although it offers fewer choices and a more limited time frame. The limitations may be offset by the woman's added experience and her understanding of the choices.

The new freedom extends to women's access to health services. The "change of life" is a socially sanctioned reason for women to apply for help, perhaps long needed and neglected. During the menopause a particularly high proportion of women seek professional services. Kessler and colleagues,[30] reviewing the evidence from four large-scale surveys of community health, concluded that, compared with men, women more readily translate nonspecific feelings of distress into the conscious recognition that they have an emotional problem.

Nevertheless, many do not recognize their problem. Munro[31] found that 10% of first attenders at a gynecologic outpatient clinic were psychiatrically unwell. This group was particularly likely to complain about menorrhagia and postmenopausal bleeding. Likewise, Ballinger,[32] studying psychiatric morbidity in clinic attenders and in the general population, suggested that patients with depressive illness in particular have a preoccupation with physical symptoms and that these patients may be a vulnerable group with a pattern of experiencing psychiatric symptoms in relation to stressors, of which the menopause is one. Many other factors, such as dysmenorrhea, limited education, sexual or marital problems, and negative sociocultural perceptions have been reported to identify this group; however, the techniques of sampling and analysis have varied widely.[2]

Further study of the attributes of women in whom psychiatric symptoms develop during the menopause and of their management is needed. At present the evidence for the importance of social and psychologic factors in the genesis of psychiatric disorders during the menopause is stronger than is that for biologic factors.

Unfortunately, cultural attitudes, especially sex-role stereotypes, may influence the quality of mental health services and can create barriers to the delivery of care to women.[33]

Clinical observations

Although the bulk of the literature fails to support the traditional concept of a single, universally experienced clinical syndrome during the menopause, there is evidence that some women experience psychiatric morbidity in an incompletely defined relationship to the menopause.[2,3,6,8,18,31,32,34–36] Physicians who become involved in the assessment and treatment of such women must be able to view the menopause as an occurrence shared by many women working through mid-life tasks. They must develop an understanding of the issues that become important during this phase of life. The approach to treatment is more complex than simply rectifying a hormonal deficiency. Our experience at St. Boniface General Hospital has convinced us that one needs to take a comprehensive biologic and psychosocial approach to treatment, as in the following case.

A 56-year-old married woman related that she had never felt happy in her life but had been feeling progressively sadder, more anxious and more hopeless for 5 years. She had been amenorrheic for 3 years and had experienced vasomotor symptoms for 2 years despite a prescription for medroxyprogesterone acetate (Provera). For several months she had experienced insomnia and had wakened during the night drenched with perspiration.

She related her sadness to lifelong feelings of inadequacy. As a child she had been given no praise and was constantly criticized by her mother, a trend continuing to the present. As a woman she had been unable to conceive. As a mother she perceived antisocial and schizoid traits in her adopted children. She had spent the last 2 years worrying about the impending retirement of her husband, a diabetic sales representative whom she described as a workaholic. She noted sadly that most of her friends, and even her 74-year-old mother, worked full time, yet she resisted her own urge to work outside the home.

Underneath her passive dependency was a great deal of anger toward those to whom she felt inferior, notably her mother and her husband. Her husband consistently denied any ailment, a reaction that did not help the therapy. Over the course of 15 months, individual therapy with an "authority figure" was characterized by mere ventilation of frustration, whereas in a group focusing on assertiveness she was able to express her resentment more constructively. Just before she joined the group her complaints about vasomotor symptoms increased, and the gynecologist treating her prescribed conjugated estrogens (Premarin). She experienced some relief from these symptoms but was unable to dispel the feelings of loneliness and anxiety. Her participation in the group, however, allowed her to rehearse a new, more independent family role. She is now involved in volunteer work and is looking forward to more time for herself. Her symptoms have markedly abated, and her need for hormonal substitutes has decreased.

Management

The first step in the treatment of the patient we have described was individual assessment and therapy, so that the stressors and facilitators could be thoroughly explored. In view of the vulnerability of patients

with long-standing maladaptive personality disorders, this step is an important one.[32-34] We recommended assessment of marital communication for the spouse, but he was unwilling to participate. His denial of his own ailments enhanced his wife's guilt for "giving up" to her symptoms. Step two was analysis of the progress made in therapy. In this particular case, group therapy emerged as the best environment for treatment, as it brings together people with diverse backgrounds, education and personality but with common features related to developmental stage, frustrations and anger. A group therapy program involving 10 sessions with both educative and interactive components has been initiated in our clinic. Self-help groups, now found in many towns, focus on the challenges of the middle years, including the menopause, and can also be used as a resource by physicians.

Despite our recommendations a significant proportion of patients' spouses are unwilling to participate in counselling. Sheehy[37] described the different directions that men and women may take during the middle years, the "age 40 crucible": "While some women will pause and try to rebalance whatever distortions they feel between personal contentment and worldly aspirations. . .men . . .run harder in an even narrower track!" For some men, conformity to corporate achievement may lead to the perception that work performance is the only criterion of self-worth. They may also feel compelled to ignore all physical reminders of their advancing age. The mounting strong-mindedness of the wife and the increased emotional vulnerability of the husband may lead to a struggle and an upset in the balance of intimacy. The husband may envy his wife because she has found freedom while he has narrowed his horizons.

Although hormonal replacement therapy reduces the menopausal symptoms of vasomotor instability and atrophy of the genital mucosa and may also retard osteoporosis, there is little evidence to support its use as a primary treatment of psychologic problems in the menopause.[38] Estrogen replacement has been promoted as having secondary psychologic benefits, as it improves a patient's feelings of physical well-being, but this idea is controversial.[18,38] The advantages of estrogen replacement therapy must be carefully weighed against the disadvantages, which include an increased risk of cancer of the endometrium.

Voda[39] has concluded that if women had definitive data about the temporal aspects of the menopause, and particularly the vasomotor symptoms, they would be much better able to cope without estrogens. The conclusion arose from a study into the strategies women use to cope with hot flashes. A sample of 1041 hot flashes, with a mean duration of 3.30 minutes, was obtained for scrutiny by having 20 randomly selected women report daily on their experiences for 2 weeks. The ways that women coped included drinking liquids, standing in front of a source of cool air and showering. Among the activities that triggered the hot flashes, "sleeping, napping and dozing" ranked highest, while "emotions" ranked lowest. (One weakness in the study — and in virtually all similar studies — is the lack of objective measurements of the climacteric symptoms.) Biofeedback has also been suggested as a means to produce relief from hot flashes.[40]

Conclusions

The major feature of the menopause is change. The "change of life" may be of use to women in need of a socially sanctioned reason to go to a physician for help. Research is ongoing in a number of biologic, psychologic and social areas that should help achieve a more precise understanding of the characteristics of the subgroup of women at risk for psychiatric morbidity around the time of the menopause. Because a number of interrelated factors are involved, physicians need to take a comprehensive approach to treatment. Substitution hormonal therapy leads to limited results unless there is also awareness of the psychologic challenges the patient faces and efforts are made to activate her social support network.

References

1. VAN KEEP P: Editorial note. *Maturitas* 1979; 1: 227
2. CHRISTIE BROWN JRW, CHRISTIE BROWN ME: Psychiatric disorders associated with the menopause. In BEARD RJ (ed): *The Menopause*, Univ Park, Baltimore, Md, 1976: 57–79
3. NEUGARTEN BL, KRAINES RJ: 'Menopausal symptoms' in women of various ages. *Psychosom Med* 1965; 27: 266–273
4. KAUFERT P, SYROTUIK J: Symptom reporting at the menopause. *Soc Sci Med* 1981; 15: 173–184
5. AKISKAL HS, WEBB WL: Affective disorders: I. Recent advances in clinical conceptualization. *Hosp Community Psychiatry* 1983; 34: 695–702
6. WEISSMAN MM, KLERMAN GL: Sex differences and the epidemiology of depression. *Arch Gen Psychiatry* 1977; 34: 98–111
7. WEISSMAN MM, MYERS JK: Affect disorders in a U.S. urban community. *Arch Gen Psychiatry* 1978; 35: 1304–1311
8. WINOKUR G: Depression in the menopause. *Am J Psychiatry* 1973; 130: 92–93
9. WINOKUR G, CADORET R: The irrelevance of menopause to depressive illness. In SACHAR EJ (ed): *Topics in Psychoneuroendocrinology*, Grune, New York, 1975: 55–66
10. ADAMOPOULOS DA, LORAINE JA, DOVE GA: Endocrinological studies in women approaching the menopause. *J Obstet Gynaecol Br Commonw* 1971; 78: 62–79
11. PRANGE AJ JR, BREESE GR, WILSON IC et al: Pituitary and suprapituitary hormones: brain behavioural effects. In SACHAR EJ (ed): *Topics in Psychoneuroendocrinology*, Grune, New York, 1975: 105–119
12. SACHAR EJ (ed): Neuroendocrine abnormalities in depressive illness. Ibid: 135–156
13. CARROLL BJ: Psychoendocrine relationships in affective disorders. In HILL OW (ed): *Modern Trends in Psychosomatic Medicine*, vol 3, Butterworth, Boston, 1976: 121–153
14. ETTIGI DG, BROWN GM: Psychoneuroendocrinology of affective disorders: an overview. *Am J Psychiatry* 1977; 134: 493–501
15. MELTZER HY, FANG VS, TRICAN BJ et al: Effect of dexamethasone on plasma prolactin and cortisol levels in psychiatric patients. *Am J Psychiatry* 1982; 139: 763–768
16. AMSTERDAM JD, WINOKUR A, LUCKI I et al: Neuroendocrine regulation in depressed postmenopausal women and healthy subjects. *Acta Psychiatry Scand* 1983; 67: 43–49
17. ABRAMOWITZ ES, BAKER AH, FLEISCHER SF: Onset of depressive psychiatric crisis and the menstrual cycle. *Am J Psychiatry* 1982; 139: 475–478
18. COULAM CB: Age, estrogens and the psyche. *Clin Obstet Gynecol* 1981; 24: 219–229
19. ENDICOTT J, HALBREICH U, SCHACT S et al: Premenstrual changes and affective disorders. *Psychosom Med* 1981; 34: 519–529
20. SARRELL PM: Sex problems after menopause: a study of fifty married couples

treated in a sex counselling programme. *Maturitas* 1982; 4: 231–237

21. NEUGARTEN BL, WOOD V, KRAINES RJ et al: Women's attitudes towards the menopause. *Vita Humana* 1963; 6: 140–151
22. DEUTSCH HS: *The Psychology of Women: II. The Climacterium*, Bantam, New York, 1945: 476–508
23. PARLEE MB: Social factors in the psychology of menstruation, birth and menopause. *Primary Care* 1976; 3: 477–490
24. KAUFERT P: Anthropology and the menopause: the development of a theoretical framework. *Maturitas* 1982; 4: 181–193
25. RUBIN LB: *Women of a Certain Age: the Mid-Life Search for Self*, Har-Row, New York, 1979
26. BECKER E: *The Denial of Death*, Free Pr, New York, 1973: 214–217
27. KAUFERT PA: Myth and the menopause. *Sociol Health Illness* 1982; 4: 141–166
28. NADELSON CC, NOTMAN MT: *The Woman Patient*, vol 2: *Concepts of Feminity and the Life Cycle*, Plenum Pub, New York, 1982: 135–158
29. ERIKSON EH: *Childhood and Society*, Norton, New York, 1950: 247–274
30. KESSLER RC, BROWN RL, BROMAN CL: Sex differences in psychiatric help-seeking: evidence from four large-scale surveys. *J Health Soc Behav* 1981; 22: 49–64
31. MUNRO A: Psychiatric illness in gynaecological outpatients: a preliminary study. *Br J Psychiatry* 1969; 115: 807–809
32. BALLINGER CB: Psychiatric morbidity and the menopause: clinical features. *Br Med J* 1976; 1: 1183–1185
33. CARMEN E, RUSSO NF, MILLER JB: Inequality and women's mental health: an overview. *Am J Psychiatry* 1981; 138: 1319–1330
34. BALLINGER CB: Psychiatric morbidity and the menopause: survey of a gynaecological outpatient clinic. *Br J Psychiatry* 1977; 131: 83–89
35. BUNGAY GT, VESSEY MD, MCPHERSON CK: Study of symptoms in middle life with special reference to menopause. *Br Med J* 1980; 281: 181–183
36. JASZMANN LJB: Epidemiology of the climacteric syndrome. In CAMPBELL S (ed): *The Management of the Menopause and Post Menopause Years*, Univ Park, Baltimore, Md, 1976: 11–23
37. SHEEHY G: *Passages*, Bantam, New York, 1976: 394–439
38. BASTEL B, CORNONI-HUNTLEY I, BRODY JA: Estrogen use and post-menopausal women: a basis for informed decisions. *J Fam Pract* 1980; 2: 851–860
39. VODA A: Climacteric hot flash. *Maturitas* 1981; 3: 73–90
40. WINEBURG E, KRONENBERG F, KHANUKAYEV E et al: Hot flashes: modification of temperature response through biofeedback and hypotherapy. In *Abstract Proceedings, Annual Meeting, Biofeedback Society of America*, March 1983